

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER b: HOSPITALS AND AMBULATORY CARE FACILITIES

PART 250
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299 AUTHORITY: Implementing and authorized by the Hospital Licensing Act [210 ILCS 85].

300

SOURCE: Rules repealed and new rules adopted August 27, 1978; emergency amendment at 2 Ill. Reg. 31, p. 73, effective July 24, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 21, p. 49, effective May 16, 1978; emergency amendment at 2 Ill. Reg. 31, p. 73, effective July 24, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 45, p. 85, effective November 6, 1978; amended at 3 Ill. Reg. 17, p. 88, effective April 22, 1979; amended at 4 Ill. Reg. 22, p. 233, effective May 20, 1980; amended at 4 Ill. Reg. 25, p. 138, effective June 6, 1980; amended at 5 Ill. Reg. 507, effective December 29, 1980; amended at 6 Ill. Reg. 575, effective December 30, 1981; amended at 6 Ill. Reg. 1655, effective January 27, 1982; amended at 6 Ill. Reg. 3296, effective March 15, 1982; amended at 6 Ill. Reg. 7835 and 7838, effective June 17, 1982; amended at 7 Ill. Reg. 962, effective January 6, 1983; amended at 7 Ill. Reg. 5218 and 5221, effective April 4, 1983 and April 5, 1983; amended at 7 Ill. Reg. 6964, effective May 17, 1983; amended at 7 Ill. Reg. 8546, effective July 12, 1983; amended at 7 Ill. Reg. 9610, effective August 2, 1983; codified at 8 Ill. Reg. 19752; amended at 8 Ill. Reg. 24148, effective November 29, 1984; amended at 9 Ill. Reg. 4802, effective April 1, 1985; amended at 10 Ill. Reg. 11931, effective September 1, 1986; amended at 11 Ill. Reg. 10283, effective July 1, 1987; amended at 11 Ill. Reg. 10642, effective July 1, 1987; amended at 12 Ill. Reg. 15080, effective October 1, 1988; amended at 12 Ill. Reg. 16760, effective October 1, 1988; amended at 13 Ill. Reg. 13232, effective September 1, 1989; amended at 14 Ill. Reg. 2342, effective February 15, 1990; amended at 14 Ill. Reg. 13824, effective September 1, 1990; amended at 15 Ill. Reg. 5328, effective May 1, 1991; amended at 15 Ill. Reg. 13811, effective October 1, 1991; amended at 17 Ill. Reg. 1614, effective January 25, 1993; amended at 17 Ill. Reg. 17225, effective October 1, 1993; amended at 18 Ill. Reg. 11945, effective July 22, 1994; amended at 18 Ill. Reg. 15390, effective October 10, 1994; amended at 19 Ill. Reg. 13355, effective September 15, 1995; emergency amendment at 20 Ill. Reg. 474, effective January 1, 1996, for a maximum of 150 days; emergency expired May 29, 1996; amended at 20 Ill. Reg. 3234, effective February 15, 1996; amended at 20 Ill. Reg. 10009, effective July 15, 1996; amended at 22 Ill. Reg. 3932, effective February 13, 1998; amended at 22 Ill. Reg. 9342, effective May 20, 1998; amended at 23 Ill. Reg. 1007, effective January 15, 1999; emergency amendment at 23 Ill. Reg. 3508, effective March 4, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9513, effective August 1, 1999; amended at 23 Ill. Reg. 13913, effective November 15, 1999; amended at 24 Ill. Reg. 6572, effective April 11, 2000; amended at 24 Ill. Reg. 17196, effective November 1, 2000; amended at 25 Ill. Reg. 3241, effective February 15, 2001; amended at 27 Ill. Reg. 1547, effective January 15, 2003; amended at 27 Ill. Reg. 13467, effective July 25, 2003; amended at 28 Ill. Reg. 5880, effective March 29, 2004; amended at 28 Ill. Reg. 6579, effective April 15, 2004; amended at 29 Ill. Reg. 12489, effective July 27, 2005; amended at 31 Ill. Reg. 4245, effective February 20, 2007; amended at 31 Ill. Reg. 14530, effective October 3, 2007; amended at 32 Ill. Reg. 3756, effective February 27, 2008; amended at 32 Ill. Reg. 4213, effective March 10, 2008; amended at 32 Ill. Reg. 7932, effective May 12, 2008; amended at 32 Ill. Reg. 14336, effective August 12, 2008; amended at 33 Ill. Reg. 8306, effective June 2, 2009; amended at 34 Ill. Reg. 2528, effective January 27, 2010; amended at 34 Ill. Reg. 3331, effective February 24, 2010; amended at 34 Ill. Reg. 19031, effective November 17, 2010; amended at 34 Ill. Reg. 19158, effective November 23, 2010; amended at 35 Ill. Reg. 4556, effective March 4, 2011; amended at 35 Ill. Reg. 6386, effective March 31, 2011; amended at 35 Ill. Reg. 13875, effective

344 August 1, 2011; amended at 36 Ill. Reg. 17413, effective December 3, 2012; amended at 38 Ill.
 345 Reg. 13280, effective June 10, 2014; amended at 39 Ill. Reg. 5443, effective March 25, 2015;
 346 amended at 39 Ill. Reg. 13041, effective September 3, 2015; amended at 41 Ill. Reg. 7154,
 347 effective June 12, 2017; amended at 41 Ill. Reg. 14945, effective November 27, 2017; amended
 348 at 42 Ill. Reg. 9507, effective May 24, 2018; amended at 43 Ill. Reg. 3889, effective March 18,
 349 2019; amended at 43 Ill. Reg. 12990, effective October 22, 2019; emergency amendment at 44
 350 Ill. Reg. 5934, effective March 25, 2020, for a maximum of 150 days; emergency expired August
 351 21, 2020; emergency amendment at 44 Ill. Reg. 7788, effective April 16, 2020, for a maximum
 352 of 150 days; emergency repeal of emergency amendment at 44 Ill. Reg. 14333, effective August
 353 24, 2020; emergency amendment at 44 Ill. Reg. 14804, effective August 24, 2020, for a
 354 maximum of 150 days; emergency expired January 20, 2021; amended at 44 Ill. Reg. 18379,
 355 effective October 29, 2020; emergency amendment at 45 Ill. Reg. 1202, effective January 8,
 356 2021, for a maximum of 150 days; emergency amendment expired June 6, 2021; emergency
 357 amendment at 45 Ill. Reg. 1715, effective January 21, 2021, for a maximum of 150 days;
 358 emergency expired June 19, 2021; emergency amendment at 45 Ill. Reg. 7544, effective June 7,
 359 2021, for a maximum of 150 days; emergency expired November 3, 2021; emergency
 360 amendment at 45 Ill. Reg. 8096, effective June 15, 2021, for a maximum of 150 days; emergency
 361 expired November 11, 2021; emergency amendment at 45 Ill. Reg. 8503, effective June 20,
 362 2021, for a maximum of 150 days; emergency expired November 16, 2021; emergency
 363 amendment at 45 Ill. Reg. 11907, effective September 17, 2021, for a maximum of 150 days;
 364 emergency expired February 13, 2022; emergency amendment at 45 Ill. Reg. 14519, effective
 365 November 4, 2021, for a maximum of 150 days; emergency expired April 2, 2022; emergency
 366 amendment at 45 Ill. Reg. 15115, effective November 12, 2021 through December 31, 2021;
 367 emergency amendment at 45 Ill. Reg. 15375, effective November 17, 2021, for a maximum of
 368 150 days; emergency expired April 15, 2022; emergency amendment at 46 Ill. Reg. 1911,
 369 effective January 13, 2022, for a maximum of 150 days; emergency expired June 11, 2022;
 370 emergency amendment at 46 Ill. Reg. 3208, effective February 14, 2022, for a maximum of 150
 371 days; emergency expired July 13, 2022; emergency amendment at 46 Ill. Reg. 6142, effective
 372 April 3, 2022, for a maximum of 150 days; emergency expired August 30, 2022; emergency
 373 amendment at 46 Ill. Reg. 6808, effective April 16, 2022, for a maximum of 150 days;
 374 emergency expired September 12, 2022; amended at 46 Ill. Reg. 8914, effective May 12, 2022;
 375 emergency amendment at 46 Ill. Reg. 10950, effective June 12, 2022, for a maximum of 150
 376 days; emergency amendment to emergency rule at 46 Ill. Reg. 12643, effective July 6, 2022, for
 377 the remainder of the 150 days; emergency expired November 8, 2022; emergency amendment at
 378 46 Ill. Reg. 13344, effective July 14, 2022, for a maximum of 150 days; emergency amendment
 379 to emergency rule at 46 Ill. Reg. 18185, effective October 27, 2022, for the remainder of the 150
 380 days; emergency expired December 10, 2022; emergency amendment at 46 Ill. Reg. 15824,
 381 effective August 31, 2022, for a maximum of 150 days; emergency expired January 27, 2023;
 382 amended at 46 Ill. Reg. 15597, effective September 1, 2022; emergency amendment at 46 Ill.
 383 Reg. 16271, effective September 13, 2022, for a maximum of 150 days; emergency expired
 384 February 9, 2023; emergency amendment at 46 Ill. Reg. 18902, effective November 9, 2022, for
 385 a maximum of 150 days; emergency expired April 7, 2023; amended at 46 Ill. Reg. 18995,
 386 effective November 10, 2022; emergency amendment at 46 Ill. Reg. 20211, effective December

11, 2022, for a maximum of 150 days; emergency expired May 9, 2023; emergency amendment at 47 Ill. Reg. 2189, effective January 28, 2023, for a maximum of 150 days; emergency expired June 26, 2023; emergency amendment at 47 Ill. Reg. 2862, effective February 10, 2023 through May 11, 2023; amended at 47 Ill. Reg. 6477, effective April 27, 2023; emergency amendment at 47 Ill. Reg. 8896, effective June 8, 2023, for a maximum of 150 days; SUBPART G recodified at 47 Ill. Reg. 8964; emergency amendment at 47 Ill. Reg. 9499, effective June 27, 2023, for a maximum of 150 days; emergency expired November 23, 2023; amended at 47 Ill. Reg. 14455, effective September 26, 2023; amended at 47 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL PROVISIONS

Section 250.105 Incorporated and Referenced Materials

a) The following regulations and standards are incorporated in this Part:

1) Private and Professional Association Standards

- A) American Society for Testing and Materials (ASTM), Standard No. E90-99 (2009): Standard Test Method for Laboratory Measurement of Airborne Sound Transmission Loss of Building Partitions and Elements, which may be obtained from the American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959
- B) ASTM E 662 (2012), Standard Test Method for Specific Optical Density of Smoke Generated by Solid Materials, which may be obtained from the American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959
- C) ASTM E 84 (2010), Standard Test Method for Surface Burning Characteristics of Building Materials, which may be obtained from the American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959
- D) The following standards of the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE), which may be obtained from the American Society of Heating, Refrigerating, and Air-Conditioning Engineers, Inc., 180 Technology Parkway NW, Peachtree, GA 30092:

i) ASHRAE Handbook of Fundamentals (2009)

- ii) ASHRAE Handbook for HVAC Systems and Equipment (2004)
- iii) ASHRAE Handbook-HVAC Applications (2007)
- iv) ASHRAE Guideline 12-2020, "Managing the Risk of Legionellosis Associated with Building Water Systems" (March 30, 2021)
- v) ASHRAE Standard 188-2021, "Legionellosis: Risk Management for Building Water Systems" (August 2021)

E) The following standards of the National Fire Protection Association (NFPA), which may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169:

- i) NFPA 101 (2012): Life Safety Code and all applicable references under Chapter 2, Referenced Publications
- ii) NFPA 101A (2013): Guide on Alternative Approaches to Life Safety

F) American Academy of Pediatrics and American College of Obstetricians and Gynecologists, Guidelines for Perinatal Care, Eighth Edition (September 2017), which may be obtained from the American College of Obstetricians and Gynecologists online at acog.org/store or by phone at 800-762-2264, 409 12th Street SW, Washington, DC 20024-2188 (See Section 250.1820.)

G) American College of Obstetricians and Gynecologists, Guidelines for Women's Healthcare, Fourth Edition (2014), which may be obtained from the American College of Obstetricians and Gynecologists online at: <https://dl-manual.com/doc/american-college-of-obstetricians-and-gynecologists-guidelines-for-womens-health-care-a-resource-manual-8z6dgqx94qol> (See Section 250.1820.)

H) American Academy of Pediatrics (AAP), Red Book: Report of the Committee on Infectious Diseases, 32nd Edition (January 2021), available at: <https://publications.aap.org/redbook> or from the American Academy of Pediatrics, 345 Park Blvd., Itasca, IL 60143 (See Section 250.1820.)

- I) American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, Part 4: Pediatric and Basics and Advanced Life Support and Part 5: Neonatal Resuscitation (October 2020), available at: <https://tinyurl.com/38zny85p> https://www.ahajournals.org/toc/circ/142/16-suppl_2 or from the American Heart Association, 7272 Greenville Ave., Dallas, TX 75231 (See Section 250.1830.)
- J) National Association of Neonatal Nurses, Position Statement #3074 Minimum RN Staffing in the NICU (September 2021), available at: <http://nann.org/about/position-statements> or from the National Association of Neonatal Nurses, 8735 W. Higgins Road, Suite 300, Chicago, IL 60631 (See Section 250.1830.)
- K) National Council on Radiation Protection and Measurements (NCRP), Report 49: Structural Shielding Design and Evaluation for Medical Use of X-rays and Gamma Rays of Energies up to 10 MeV (1976) and NCRP Report 102: Medical X-Ray, Electron Beam and Gamma-Ray Protection for Energies Up to 50 MeV (Equipment Design, Performance and Use) (1989), which may be obtained from the National Council on Radiation Protection and Measurements, 7910 Woodmont Ave., Suite 400, Bethesda, Maryland 20814-3095 (See Sections 250.2440 and 250.2450.)
- L) DOD Penetration Test Method MIL STD 282 (2012): Filter Units, Protective Clothing, Gas-mask Components and Related Products: Performance Test Methods, available at: <https://webstore.ansi.org/standards/dod/milstd282> <https://global.ihs.com/standards/cfm?publisher=NPFC> (See Section 250.2480.)
- M) National Association of Plumbing-Heating-Cooling Contractors (PHCC), National Standard Plumbing Code (2009), which may be obtained from the National Association of Plumbing-Heating-Cooling Contractors, 180 S. Washington Street, Suite 100, Falls Church, VA 22046 (703-237-8100)
- N) International Building Code (2012), which may be obtained from the International Code Council, 4051 Flossmoor Road, Country Club Hills, IL 60478 (See Section 250.2420.)

- O) American National Standards Institute, ANSI A117.1 (2009), Standard for Accessible and Usable Buildings, which may be obtained from the American National Standards Institute, 25 West 43rd Street, 4th Floor, New York, NY 10036 (See Section 250.2420.)
- P) ASME Standard A17.1-2007, Safety Code for Elevators and Escalators, which may be obtained from the American Society of Mechanical Engineers (ASME) International, 22 Law Drive, Box 2900, Fairfield, NJ 07007-2900
- Q) Accreditation Council for Graduate Medical Education, Common Program Requirements (Residency) (2022), available at: https://www.acgme.org/globalassets/PFAssets/ProgramRequirements/CPRResidency_2022v2.pdf or from the Accreditation Council for Graduate Medical Education, 401 N. Michigan Ave., Suite 2000, Chicago, IL 60611 (See Section 250.315.)
- R) The Joint Commission, 2022 Hospital Accreditation Standards (HAS), available at: <https://store.jcrinc.com/2022-accreditation-standards-books/> or from the Joint Commission, 1515 W. 22nd St. Ste. 1300W, Oakbrook Terrace, IL 60523 (See Section 250.1035.)
- S) National Quality Forum, Safe Practices for Better Health Care (2010), available at: https://www.qualityforum.org/publications/2010/04/safe_practices_for_better_healthcare_%E2%80%93_2010_update.aspx or from the National Quality Forum, 10991 14th Street NW, Suite 500, Washington DC 20005, or from www.qualityforum.org

2) Federal Government Publications

- A) Department of Health and Human Services, Centers for Disease Control and Prevention, "2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" (May 2022) available at: <https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf>
- B) Department of Health and Human Services, Centers for Disease Control and Prevention, Infection Control in Healthcare Personnel, available in two parts: "Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services" (October

25, 2019) and "Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients" (November 5, 2021), both available at: <https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html>

- C) Department of Health and Human Services, Centers for Disease Control and Prevention, "Guidelines for Environmental Infection Control in Health-Care Facilities": (July 2019), available at: <https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html>
- D) Department of Health and Human Services, Centers for Disease Control and Prevention, Guideline for Hand Hygiene in Health Care Settings (October 2002) available at: <https://www.cdc.gov/infectioncontrol/guidelines/hand-hygiene/index.html>
- E) Department of Health and Human Services, Centers for Disease Control and Prevention, "Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008", (May 2019), available at: <https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf>
- F) Department of Health and Human Services, Centers for Disease Control and Prevention, "Core Elements of Hospital Stewardship Programs", (2019), which is available at: <https://www.cdc.gov/antibiotic-use/healthcare/pdfs/hospital-core-elements-H.pdf>, and "Implementation of Antibiotic Stewardship Core Elements at Small and Critical Access Hospitals", which is available at: <https://www.cdc.gov/antibiotic-use/core-elements/small-critical.html> ~~<https://www.cdc.gov/antibiotic-use/core-elements-small-critical.html>~~
- G) Department of Health and Human Services, Centers for Disease Control and Prevention, "Toolkit for Controlling Legionella in Common Sources of Exposure", which is available at: <https://www.cdc.gov/legionella/wmp/control-toolkit/index.html>
- H) National Center for Health Statistics and World Health Organization, Geneva, Switzerland, "International Classification of Diseases", 11th Revision (ICD-11), (2022), available at:

<https://www.who.int/standards/classifications/classification-of-diseases>

- I) U.S. Department of Labor, Occupational Safety and Health Administration, "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" (OSHA 3148-06R 2016), available at:
<https://www.osha.gov/Publications/osha3148.pdf>
- J) Department of Health and Human Services, United States Public Health Service, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, "STOP SV: A Technical Package to Prevent Sexual Violence", available at:
<https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf>

3) Federal Regulations

- A) 45 CFR 46.101, To What Does the Policy Apply? (October 1, 2021)
- B) 45 CFR 46.103(b), Assuring Compliance with this Policy – Research Conducted or Supported by any Federal Department or Agency (October 1, 2021)
- C) 42 CFR 482, Conditions of Participation for Hospitals (October 1, 2021)
- D) 21 CFR, Food and Drugs (April 1, 2021)
- E) 42 CFR 489.20, Basic Commitments (October 1, 2021)
- F) 29 CFR 1910.1030, Bloodborne Pathogens (July 1, 2021)
- G) 42 CFR 413.65(d) and (e), Requirements for a determination that a facility or an organization has provider-based status (October 1, 2021)
- H) [42 CFR 493, Laboratory Requirements \(CLIA regulations\) \(October 1, 2021\)](#)

- 643 b) All incorporations by reference of federal regulations and guidelines and the
644 standards of nationally recognized organizations refer to the regulations,
645 guidelines and standards on the date specified and do not include any editions or
646 amendments subsequent to the date specified.
647
- 648 c) The following statutes and State regulations are referenced in this Part:
649
- 650 1) State of Illinois Statutes
651
- 652 A) Hospital Licensing Act [210 ILCS 85]
653
- 654 B) Illinois Health Facilities Planning Act [20 ILCS 3960]
655
- 656 C) Medical Practice Act of 1987 [225 ILCS 60]
657
- 658 D) Podiatric Medical Practice Act of 1987 [225 ILCS 100]
659
- 660 E) Pharmacy Practice Act [225 ILCS 85]
661
- 662 F) Physician Assistant Practice Act of 1987 [225 ILCS 95]
663
- 664 G) Illinois Clinical Laboratory and Blood Bank Act [210 ILCS 25]
665
- 666 H) X-Ray Retention Act [210 ILCS 90]
667
- 668 I) Safety Glazing Materials Act [430 ILCS 60]
669
- 670 J) Mental Health and Developmental Disabilities Code [405 ILCS 5]
671
- 672 K) Nurse Practice Act [225 ILCS 65]
673
- 674 L) Health Care Worker Background Check Act [225 ILCS 46]
675
- 676 M) MRSA Screening and Reporting Act [210 ILCS 83]
677
- 678 N) Hospital Report Card Act [210 ILCS 86]
679
- 680 O) Illinois Adverse Health Care Events Reporting Law of 2005 [410
681 ILCS 522]
682
- 683 P) Smoke Free Illinois Act [410 ILCS 82]
684
- 685 Q) Health Care Surrogate Act [755 ILCS 40]

- R) Perinatal HIV Prevention Act [410 ILCS 335]
- S) Hospital Infant Feeding Act [210 ILCS 81]
- T) Medical Patient Rights Act [410 ILCS 50]
- U) Hospital Emergency Service Act [210 ILCS 80]
- V) Illinois Anatomical Gift Act [755 ILCS 50]
- W) Illinois Public Aid Code [305 ILCS 5]
- X) Substance Use Disorder Act [20 ILCS 301]
- Y) ID/DD Community Care Act [210 ILCS 47]
- Z) Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49]
- AA) Veterinary Medicine and Surgery Practice Act of 2004 [225 ILCS 115]
- BB) Alternative Health Care Delivery Act [210 ILCS 3]
- CC) Gestational Surrogacy Act [750 ILCS 47]
- DD) Code of Civil Procedure (Medical Studies) [735 ILCS 5/8-2101]
- EE) Sexual Assault Survivors Emergency Treatment Act [410 ILCS 70]
- FF) Civil Administrative Code of Illinois (Department of Public Health Powers and Duties Law) [20 ILCS 2310]
- GG) AIDS Confidentiality Act [410 ILCS 305]
- HH) Nursing Home Care Act [210 ILCS 45]
- II) Illinois Controlled Substances Act [720 ILCS 570]
- JJ) Early Hearing Detection and Intervention Act [410 ILCS 213]

- KK) Home Health, Home Services, and Home Nursing Agency
Licensing Act [210 ILCS 55]
- LL) Health Care Violence Prevention Act [210 ILCS 160]
- MM) Illinois Health Finance Reform Act [20 ILCS 2215]
- NN) Fair Patient Billing Act [210 ILCS 88]
- OO) Crime Victims Compensation Act [740 ILCS 45]
- PP) Human Trafficking Resource Center Notice Act [775 ILCS 50]
- QQ) Abandoned Newborn Infant Protection Act [325 ILCS 2]
- RR) Emergency Medical Services (EMS) Systems Act [210 ILCS 50]
- SS) Radiation Protection Act of 1990 [420 ILCS 40]
- TT) Illinois Dental Practice Act [225 ILCS 25]
- UU) Criminal Identification Act [20 ILCS 2630]

2) State of Illinois Administrative Rules

- A) Department of Public Health, Illinois Plumbing Code (77 Ill. Adm. Code 890)
- B) Department of Public Health, Sexual Assault Survivors Emergency Treatment Code (77 Ill. Adm. Code 545)
- C) Department of Public Health, Control of Communicable Diseases Code (77 Ill. Adm. Code 690)
- D) Department of Public Health, Food Code (77 Ill. Adm. Code 750)
- E) Department of Public Health, Public Area Sanitary Practice Code (77 Ill. Adm. Code 895)
- F) Department of Public Health, Maternal Death Review (77 Ill. Adm. Code 657)

- 771 G) Department of Public Health, Control of Sexually Transmissible
772 Infections Code (77 Ill. Adm. Code 693)
773
- 774 H) Department of Public Health, Control of Tuberculosis Code (77 Ill.
775 Adm. Code 696)
776
- 777 I) Department of Public Health, Health Care Worker Background
778 Check Code (77 Ill. Adm. Code 955)
779
- 780 J) Department of Public Health, Language Assistance Services Code
781 (77 Ill. Adm. Code 940)
782
- 783 K) Department of Public Health, Regionalized Perinatal Health Care
784 Code (77 Ill. Adm. Code 640)
785
- 786 L) Health Facilities and Services Review Board, Narrative and
787 Planning Policies (77 Ill. Adm. Code 1100)
788
- 789 M) Health Facilities and Services Review Board, Processing,
790 Classification Policies and Review Criteria (77 Ill. Adm. Code
791 1110)
792
- 793 N) Department of Public Health, Private Sewage Disposal Code (77
794 Ill. Adm. Code 905)
795
- 796 O) Department of Public Health, Ambulatory Surgical Treatment
797 Center Licensing Requirements (77 Ill. Adm. Code 205)
798
- 799 P) Department of Public Health, HIV/AIDS Confidentiality and
800 Testing Code (77 Ill. Adm. Code 697)
801
- 802 Q) Capital Development Board, Illinois Accessibility Code (71 Ill.
803 Adm. Code 400)
804
- 805 R) State Fire Marshal, Boiler and Pressure Vessel Safety (41 Ill. Adm.
806 Code 120)
807
- 808 S) State Fire Marshal, Fire Prevention and Safety (41 Ill. Adm. Code
809 100)
810
- 811 T) Illinois Emergency Management Agency, Standards for Protection
812 Against Radiation (32 Ill. Adm. Code 340)
813

- U) Illinois Emergency Management Agency, Use of X-rays in the Healing Arts Including Medical, Dental, Podiatry, and Veterinary Medicine (32 Ill. Adm. Code 360)
- V) Illinois Emergency Management Agency, Medical Use of Radioactive Material (32 Ill. Adm. Code 335)
- W) Illinois Emergency Management Agency, Registration and Operator Requirements for Radiation Installations (32 Ill. Adm. Code 320)
- X) Illinois Emergency Management Agency, Accrediting Persons in the Practice of Medical Radiation Technology (32 Ill. Adm. Code 401)
- Y) Illinois Emergency Management Agency, General Provisions for Radiation Protection (32 Ill. Adm. Code 310)
- 3) Federal Statutes
 - A) Health Insurance Portability and Accountability Act of 1996 (110 U.S.C. 1936)
 - B) Emergency Medical Treatment & Labor Act (42 U.S.C. 1395dd)
- 4) Federal Training Materials
 - A) Preventing Workplace Violence in Healthcare, available at: <https://www.oshatrain.org/courses/mods/776e.html>
 - B) Workplace Violence Prevention for Nurses, available at: <https://www.cdc.gov/niosh/topics/violence/>

(Source: Amended at 47 Ill. Reg. _____, effective _____)

SUBPART C: THE MEDICAL STAFF

Section 250.310 Organization

- a) For the purposes of this Section only:
 - 1) *Adverse Decision* – means a decision reducing, restricting, suspending, revoking, denying, or not renewing medical staff membership or clinical

privileges. (Section 10.4(b) of the Act)

- 2) A Distant-site Hospital – ~~means~~~~mean~~ an Illinois licensed hospital or a Medicare participating hospital.
- 3) A Distant-site Telemedicine Entity – means an entity consisting of a group of licensed physicians that:
 - A) Provides telemedicine services;
 - B) Is not a Medicare-participating hospital; and
 - C) Provides contracted services in a manner that enables a hospital using its services to meet all applicable Medicare conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of a hospital. A distant-site telemedicine entity would include a distant-site hospital that does not participate in the Medicare program that is providing telemedicine services to a Medicare-participating hospital.
- 4) *Economic Factor* – *means any information or reasons for decisions unrelated to quality of care or professional competency.* (Section 10.4(b) of the Act)
- 5) Non-simultaneously – means that, while the telemedicine physician or practitioner still provides clinical services to the patient upon a formal request from the patient's attending physician, these services may, for example, involve after-the-fact interpretation of diagnostic tests, consultations between a physician or practitioner and a person outside the State of Illinois, or second opinions provided to an Illinois-licensed physician in order to provide an assessment of the patient's condition and do not necessarily require the telemedicine practitioner to directly assess the patient in real time or establish a provider-to-patient relationship or interaction. An example of after-the-fact interpretation of diagnostic tests~~This~~ would be similar to the services provided by an on-site radiologist who interprets a patient's x-ray or CT scan and then communicates the assessment to the patient's attending physician who then bases a diagnosis and treatment plan on these findings.
- 6) *Privilege* – *means permission to provide medical or other patient care services and permission to use hospital resources, including equipment, facilities and personnel that are necessary to effectively provide medical*

or other patient care services. This definition shall not be construed to require a hospital to acquire additional equipment, facilities, or personnel to accommodate the granting of privileges. (Section 10.4(b) of the Act)

7) Simultaneously – means that the clinical services (for example, assessment of the patient with a clinical plan for treatment, including any medical orders needed) are provided to the patient in real time by the telemedicine physician or practitioner, similar to the actions of an on-site physician or practitioner.

8) Telemedicine – means the provision of clinical services to patients by physicians ~~or~~and practitioners ~~remotely from a distance~~ via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the hospital patient either simultaneously, as is often the case with teleICU services, for example, or non-simultaneously, as may be the case with many teleradiology services. Telemedicine may also include provider-to-provider consultations between Illinois-licensed physicians or practitioners and physicians or practitioners licensed in the United States.

b) The medical staff shall be organized in accordance with written bylaws, rules and regulations approved by the governing board. The bylaws, rules and regulations shall specifically provide, but are not limited to:

1) establishing written procedures relating to the acceptance and processing of initial applications for medical staff membership, granting and denying of medical staff reappointment, and medical staff membership or clinical privileges disciplinary matters in accordance with subsection (e) for county hospitals as defined in Section 15-1(c) of the Illinois Public Aid Code, or subsection (f) ~~of this Section~~ for all other hospitals. The procedures for initial applicants at any particular hospital may differ from those for current medical staff members. However, the procedures at any particular hospital shall be applied equally to each practitioner eligible for medical staff membership as defined in Section 250.100. The procedures shall provide that, *prior to the granting of any medical staff privileges to an applicant, or renewing a current medical staff member's privileges, the hospital shall request of the Director of the Department of Financial and Professional Regulation information concerning the licensure status, proper credentials, required certificates, and any disciplinary action taken against the applicant's or medical staff member's license.* This provision shall not apply to *medical personnel who enter a hospital to obtain organs and tissues for transplant from a deceased donor in accordance with the Illinois Anatomical Gift Act.* This provision shall not apply to *medical*

personnel who have been granted disaster privileges pursuant to the procedures and requirements established in this Section. (Section 10.4(a) of the Act);

- 2) identifying divisions and departments as are warranted (as a minimum, active and consulting divisions are required);
- 3) identifying officers as are warranted;
- 4) establishing committees as are warranted to assure the responsibility for functions such as pharmacy and therapeutics, infection control, utilization review, patient care evaluation, and the maintenance of complete medical records;
- 5) assuring that active medical staff meetings are held regularly, and that written minutes of all meetings are kept;
- 6) reviewing and analyzing the clinical experience of the hospital at regular intervals – the medical records of patients to be the basis for review and analysis;
- 7) identifying conditions or situations that require consultation, including consultation between medical staff members in complicated cases;
- 8) examining tissue removed during operations by a qualified pathologist and requiring that the findings are made a part of the patient's medical record;
- 9) keeping completed medical records;
- 10) maintaining a Utilization Review Plan, which shall be in accordance with the Conditions of Participation for Hospitals;
- 11) establishing Medical Care Evaluation Studies;
- 12) establishing policies requiring a physician as first assistant to major or hazardous surgery, including written criteria to determine when an assistant is necessary;
- 13) assuring, through credentialing by the medical staff, that a qualified surgical assistant, whether a physician or non-physician, assists the operating surgeon in the operating room;

- 14) determining additional privileges that may be granted a staff member for the use of the staff member's employed allied health personnel in the hospital in accordance with policies and procedures recommended by the medical staff and approved by the governing authority. The policies and procedures shall include, at least, requirements that the staff member requesting this additional privilege shall submit the following for review and approval by the medical staff and the governing authority of the hospital:
 - A) a curriculum vitae of the identified allied health personnel, and
 - B) a written protocol with a description of the duties, assignments and functions, including a description of the manner of performance within the hospital by the allied health personnel in relationship with other hospital staff;
- 15) establishing a mechanism for assisting medical staff members in addressing physical and mental health problems;
- 16) implementing a procedure for preserving medical staff credentialing files in the event of the closure of the hospital;
- 17) establishing a procedure for granting telemedicine privileges, based upon the privileging decisions of a distant-site hospital or telemedicine entity that has a written agreement that meets Medicare requirements; and
- 18) establishing a procedure for granting disaster privileges.
 - A) When the emergency management plan has been activated and the hospital is unable to handle patients' immediate needs, it shall:
 - i) identify in writing the individuals responsible for granting disaster privileges;
 - ii) describe in writing the responsibilities of the individuals granting disaster privileges. The responsible individual is not required to grant privileges to any individual and is expected to make decisions on a case-by-case basis at his or her discretion;
 - iii) describe in writing a mechanism to manage individuals who receive disaster privileges;

- iv) include a mechanism to allow staff to readily identify individuals who receive disaster privileges;
 - v) require that medical staff address the verification process as a high priority and begin the verification process of the credentials and privileges of individuals who receive disaster privileges as soon as the immediate situation is under control.
- B) The individual responsible for granting disaster privileges may grant disaster privileges upon presentation of any of the following:
- i) a current picture hospital ID card;
 - ii) a current license to practice and a valid picture ID issued by a state, federal or regulatory agency;
 - iii) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or an Illinois Medical Emergency Response Team (IMERT);
 - iv) identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (authority having been granted by a federal, state or municipal entity); or
 - v) presentation by current hospital or medical staff members with personal knowledge regarding practitioner's identity.
- C) *Any hospital and any employees of the hospital or others involved in granting privileges who, in good faith, grant disaster privileges, pursuant to Section 10.4 of the Act, to respond to an emergency shall not, as a result of their acts or omissions, be liable for civil damages for granting or denying disaster privileges except in the event of willful and wanton misconduct, as that term is defined in Section 10.2 of the Act.*
- D) *Individuals granted privileges who provide care in an emergency situation, in good faith and without direct compensation, shall not, as a result of their acts or omissions, except for acts or omissions involving willful and wanton misconduct, as that term is defined in Section 10.2 of the Act, on the part of the person, be liable for civil damages. (Section 10.4 of the Act)*

- c) General Acute or Critical Access Hospitals without a licensed pediatric unit or board certified or board eligible pediatrician in the hospital or on call 24 hours a day, 7 days a week that provide limited inpatient or observation services to pediatric patients (neonate (less than 28 days of age) to 14 years old ~~and younger~~):
- 1) Shall have a written agreement with a children's hospital or hospital with a licensed pediatric unit. The agreement shall include provider-to-patient and/or provider-to-provider consultations that meet the telemedicine requirements provided in subsections (a)(2) through (a)(8) remotely via electronic communications, whether synchronous or asynchronous, and specify other information including communication frequency, equipment, education, transfers, case reviews, and critical criteria for emergency transfers;
 - 2) Must have an agreement with one primary hospital, for the purposes of continuing education and consultation, but are encouraged to have agreements with multiple hospitals, in order to ensure options when a transfer is warranted but restricted from accommodation due to primary hospital census or family preference;
 - 3) May have agreements with out-of-state hospitals who have agreements with the Department under the Regionalized Perinatal Health Care Code (77 Ill. Adm. Code 640) and designated as a trauma center by the Department in accordance with Section 3.90 of the Emergency Medical Services (EMS) Systems Act;
 - 4) May include a fee for provider-to-patient and/or provider-to-provider consultations with the consulting hospital in the written agreement, but the fee may not be transferred to the patient;
 - 5) Have 12 months after September 1, 2022 to enter into an agreement, or amend an existing agreement, as required in this subsection (c);
 - 6) Shall consult with the children's hospital or hospital with licensed pediatric unit prior to the patient being moved to a medical/surgical unit from either the emergency department or post-operative procedure unit. In cases where the consultation cannot occur prior to the move, the consultation must occur within one hour after the patient has been placed on the medical/surgical unit as an inpatient or in observation status. The frequency of the consultations during the pediatric patient's stay shall be determined by the health care provider and shall continue until the patient is discharged or transferred;

- 7) Shall maintain a record of the consultation in the pediatric patient's medical file; ~~and~~
- 8) Shall report pediatric services provided pursuant to the requirements of this subsection (c) to the Department quarterly as required by Section 250.1520(i); ~~and~~.
- 9) Providers who give provider-to-provider consultations are not required to be privileged at the hospital where the patient is receiving treatment.

d) If a hospital is part of a hospital system consisting of two or more separately licensed hospitals, and the system elects to have a unified, integrated medical staff for its separately licensed member hospitals, each separately licensed hospital shall permit the medical staff members of each separately licensed hospital in the system (in other words, all medical staff members who hold specific privileges to practice at that hospital) to vote, in accordance with medical staff bylaws, whether to accept a unified, integrated medical staff structure or to maintain a separate and distinct medical staff for their respective licensed hospital.

- 1) If the medical staffs of the separately licensed hospitals vote to accept an integrated, unified medical staff structure, they shall meet the following conditions:
 - A) Adopt written bylaws, rules and requirements that describe the processes for self-governance, appointment, credentialing, privileging and oversight, as well as peer review policies and due process rights guarantees, including a process for the members of the medical staff of each separately licensed hospital to be advised of their rights to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their hospital;
 - B) Take into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; and
 - C) Establish and implement written policies and procedures, including meetings that shall occur at least twice per fiscal or calendar year, to ensure that the needs and concerns expressed by members of the medical staffs at each separately licensed hospital, regardless of practice or location, are given due consideration, and that the unified, integrated medical staff has mechanisms in place to ensure

that issues localized to particular hospitals are considered and addressed.

- 2) The unified, integrated medical staff shall be organized in accordance with the Conditions of Participation for Hospitals related to medical staff.
 - 3) Medical staffs may vote, no more than every two years, whether to remain or discontinue as an integrated, unified medical staff.
 - 4) This subsection (d) shall not apply to hospitals that are required to have a unified, integrated medical staff under 42 CFR 413.65(d) and (e) as being a multi-campus hospital under one Medicare certification number.
- e) The medical staff bylaws for county hospitals as defined in Section 15-1(c) of the Illinois Public Aid Code shall include at least the following:
- 1) The procedures relating to evaluating individuals for staff membership, whether the practitioners are or are not currently members of the medical staff, shall include procedures for determining qualifications and privileges; criteria for evaluating qualifications; and procedures requiring information about current health status, current license status in Illinois, and biennial review of renewed license.
 - 2) Written procedures that allow the medical staff to rely upon the credentialing and privileging decisions of a distant-site hospital or telemedicine entity as an option for recommending the privileging of telemedicine physicians.
 - 3) The procedure shall grant to current medical staff members at least: written notice of an adverse decision by the Governing Board; an explanation and reasons for an adverse decision; the right to examine and/or present copies of relevant information, if any, related to an adverse decision; an opportunity to appeal an adverse decision; and written notice of the decision resulting from the appeal. The procedures for providing written notice shall include timeframes for giving notice.
- f) The medical staff bylaws for *all hospitals except county hospitals* shall include at least the following *provisions for granting, limiting, renewing, or denying medical staff membership and clinical staff privileges*:
- 1) *Minimum procedures for pre-applicants or applicants for medical staff membership, including the following:*

- A) *Written procedures relating to the acceptance and processing of pre-applicants or applicants for medical staff membership.*
 - B) *Written procedures to be followed in determining a pre-applicant's or an applicant's qualifications for being granted medical staff membership and privileges.*
 - C) *Written criteria to be followed in evaluating a pre-applicant's or an applicant's qualifications.*
 - D) *An evaluation of a pre-applicant's or an applicant's current health status and current license status in Illinois.*
 - E) *A written response to each pre-applicant or applicant that explains the reason or reasons for any adverse decision (including all reasons based in whole or in part on the applicant's medical qualifications or any other basis, including economic factors).*
 - F) *Written procedures that allow the medical staff to rely upon the credentialing and privileging decisions of a distant-site hospital or telemedicine entity as an option for recommending the privileging of telemedicine physicians.*
- 2) *Minimum procedures with respect to medical staff and clinical privilege determinations concerning current members of the medical staff shall include the following:*
 - A) *A written notice of an adverse decision and explanation of the reasons for an adverse decision including all reasons based on the quality of medical care or any other basis, including economic factors.*
 - B) *A statement of the medical staff member's right to request a fair hearing on the adverse decision before a hearing panel whose membership is mutually agreed upon by the medical staff and the hospital governing board. The hearing panel shall have independent authority to recommend action to the hospital governing board. Upon the request of the medical staff member or the hospital governing board, the hearing panel shall make findings concerning the nature of each basis for any adverse decision recommended to and accepted by the hospital governing board.*

- i) *Nothing in this subsection (f)(2)(B) limits a hospital's or medical staff's right to summarily suspend, without a prior hearing, a person's medical staff membership or clinical privileges if the continuation of practice of a medical staff member constitutes an immediate danger to the public, including patients, visitors, and hospital employees and staff.*
- ii) *In the event that a hospital or the medical staff imposes a summary suspension, the Medical Executive Committee, or other comparable governance committee of the medical staff as specified in the bylaws, must meet as soon as is reasonably possible to review the suspension and to recommend whether it should be affirmed, lifted, expunged, or modified if the suspended medical staff member requests a review.*
- iii) *A summary suspension may not be implemented unless there is actual documentation or other reliable information that an immediate danger exists. This documentation or information must be available at the time the summary suspension decision is made and when the decision is reviewed by the Medical Executive Committee.*
- iv) *If the Medical Executive Committee recommends that the summary suspension should be lifted, expunged, or modified, this recommendation must be reviewed and considered by the hospital governing board, or a committee of the board, on an expedited basis.*
- v) *Nothing in this subsection (f)(2)(B) shall affect the requirement that any requested hearing must be commenced within 15 days after the summary suspension and completed without delay unless otherwise agreed to by the parties.*
- vi) *A fair hearing shall be commenced within 15 days after the suspension and completed without delay, except that, when the medical staff member's license to practice has been suspended or revoked by the Department of Financial and Professional Regulation, no hearing shall be necessary. (Section 10.4(b)(2)(C)(i) of the Act)*

vii) *Nothing in this subsection (f)(2)(B) limits a medical staff's right to permit, in the medical staff bylaws, summary suspension of membership or clinical privileges in designated administrative circumstances as specifically approved by the medical staff. This bylaw provision must specifically describe both the administrative circumstance that can result in a summary suspension and the length of the summary suspension. The opportunity for a fair hearing is required for any administrative summary suspension. Any requested hearing must be commenced within 15 days after the summary suspension and completed without delay. Adverse decisions other than suspension or other restrictions on the treatment or admission of patients may be imposed summarily and without a hearing under designated administrative circumstances as specifically provided for in the medical staff bylaws as approved by the medical staff. (Section 10.4(b)(2)(C)(ii) of the Act)*

viii) *If a hospital exercises its option to enter into an exclusive contract and that contract results in the total or partial termination or reduction of medical staff membership or clinical privileges of a current medical staff member, the hospital shall provide the affected medical staff member 60 days prior notice of the effect on his or her medical staff membership or privileges. An affected medical staff member desiring a hearing under this subsection (f)(2)(B) must request the hearing within 14 days after the date he or she is so notified. The requested hearing shall be commenced and completed (with a report and recommendation to the affected medical staff member, hospital governing board, and medical staff) within 30 days after the date of the medical staff member's request. If agreed upon by both the medical staff and the hospital governing board, the medical staff bylaws may provide for longer time periods. (Section 10.4(b)(2)(C)(iii) of the Act)*

C) *A statement of the member's right to inspect all pertinent information in the hospital's possession with respect to the decision.*

D) *A statement of the member's right to present witnesses and other evidence at the hearing on the decision.*

- E) *The right to be represented by a personal attorney.*
- F) *A written notice and written explanation of the decision resulting from the hearing.*
- G) *A written notice of a final adverse decision by the hospital governing board.*
- H) *Notice given 15 days before implementation of an adverse medical staff membership or clinical privileges decision based substantially on economic factors. This notice shall be given after the medical staff member exhausts all applicable procedures under subsection (f)(2)(B)(viii) ~~of this Section~~, and under the medical staff bylaws in order to allow sufficient time for the orderly provision of patient care. (Section 10.4(b)(2)(D) through (G) of the Act)*
- 3) *Nothing in subsection (f)(2) limits a medical staff member's right to waive, in writing, the rights provided in subsection (f)(2)(A) through (H) upon being granted privileges to provide telemedicine services or the written exclusive right to provide particular services at a hospital, either individually or as a member of a group. If an exclusive contract is signed by a representative of a group of physicians, a waiver contained in the contract shall apply to all members of the group unless stated otherwise in the contract. (Section 10.4(b)(2)(H) of the Act)*
- 4) *All peer review used for the purpose of credentialing, privileging, disciplinary action, or other recommendations affecting medical staff membership or exercise of clinical privileges, whether relying in whole or in part on internal or external reviews, shall be conducted in accordance with the medical staff bylaws and applicable rules, regulations, or policies of the medical staff. If external review is obtained, any adverse report utilized shall be in writing and shall be made part of the internal peer review process under the bylaws. The report shall also be shared with a medical staff peer review committee and the individual under review. If the medical staff peer review committee or the individual under review prepares a written response to the report of the external peer review within 30 days after receiving the report, the governing board shall consider the response prior to the implementation of any final actions by the governing board which may affect the individual's medical staff membership or clinical privileges. Any peer review that involves willful or wanton misconduct shall be subject to civil damages as provided for under Section 10.2 of the Act. (Section 10.4(b)(2)(C-5) of the Act)*

5) *Every adverse medical staff membership and clinical privilege decision based substantially on economic factors shall be reported to the Hospital Licensing Board before the decision takes effect. The reports shall not be disclosed in any form that reveals the identity of any hospital or physician. These reports shall be utilized to study the effects that hospital medical staff membership and clinical privilege decisions based upon economic factors have on access to care and the availability of physician services.*
(Section 10.4(b)(3) of the Act)

g) If a hospital enters into agreement for telemedicine services with a distant-site hospital or distant-site entity, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the hospital performing the credentialing and privileging requirements, to rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians providing the services. The hospital's governing body ensures, through its written agreement with the distant-site hospital, that the distant-site hospital meets the Conditions of Participation for Hospitals for credentialing and privileging of physicians. The agreement shall be in writing and shall verify:

- 1) That the distant-site hospital providing the telemedicine services is an Illinois licensed hospital or a Medicare participating hospital;
- 2) That the individual distant-site physician is privileged at the distant-site hospital that provides the telemedicine services and provides to the hospital a current list of the distant-site physician's privileges;
- 3) That the individual distant-site physician holds a license issued or recognized by the State of Illinois; and
- 4) That, if the hospital conducts an internal review of the distant-site physician's performance, it provides the distant-site hospital with the performance information for use in the distant-site hospital's periodic appraisal of the distant-site physician. At a minimum, this information shall include all adverse events that result from the telemedicine services provided by the distant-site physician to the hospital's patients and all complaints the hospital has received about the distant-site physician.

h) The hospital's governing body shall grant privileges to each telemedicine physician providing services at the hospital under an agreement with a distant-site hospital or telemedicine entity before the telemedicine physician may provide telemedicine services. The scope of the privileges granted to the telemedicine physician shall reflect the provision of the services offered via a

telecommunications system.

- i) When the hospital's governing body exercises the option to grant privileges based on its medical staff recommendations, which rely upon the privileging decisions of a distant-site telemedicine hospital or entity, the governing body may, but is not required to, maintain a separate file on each telemedicine physician. In lieu of maintaining a separate file on each telemedicine physician, the hospital may have a file on all telemedicine physicians providing services at the hospital under each agreement with a distant-site hospital or telemedicine entity, indicating which telemedicine services privileges the hospital has granted to each physician on the list. The file or files may be kept in a format determined by the hospital.
- j) Regardless of any other categories (divisions of the medical staff) having privileges in the hospital, the hospital shall have an active staff, which shall include physicians and may also include podiatrists and dentists, properly organized, who perform all the organizational duties pertaining to the medical staff. These duties include:
 - 1) Maintaining the proper quality of all medical care and treatment of inpatients and outpatients in the hospital. Proper quality of medical care and treatment includes:
 - A) availability and use of accurate diagnostic testing for the types of patients admitted;
 - B) availability and use of medical, surgical, and psychiatric treatment for patients admitted;
 - C) availability and use of consultation, diagnostic tools and treatment modalities for the care of patients admitted, including the care needed for complications that may be expected to occur; and
 - D) availability and performance of auxiliary and associate staff with documented training and experience in diagnostic and treatment modalities in use by the medical staff and documented training and experience in managing complications that may be expected to occur.
 - 2) Organization of the medical staff, including adoption of rules and regulations for its government (which require the approval of the governing body), election of its officers or recommendations to the governing body for appointment of the officers, and recommendations to

the governing body upon all appointments to the staff and grants of hospital privileges.

3) Other recommendations to the governing body regarding matters within the purview of the medical staff.

k) The medical staff may include one or more divisions in addition to the active staff, but this in no way modifies the duties and responsibilities of the active staff.

(Source: Amended at 47 Ill. Reg. _____, effective _____)

SUBPART E: LABORATORY

Section 250.510 Laboratory Services

The hospital shall have a clinical laboratory, certified in accordance with 42 CFR 493, to perform services commensurate with the hospital's needs for its patients, ~~which is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88) (57 Fed. Reg. 40, pp. 7135-7139, February 28, 1992 – Medicare, Medicaid and CLIA Programs; Regulations Implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA), no further amendments or editions included)~~. Anatomical pathology services and blood bank services shall be available either in the hospital or by arrangement with other facilities.

a) Adequacy of Laboratory Services. Clinical laboratory services adequate for the individual hospital shall be maintained in the hospital, as determined by the following:

1) The extent and complexity of services are commensurate with size, scope and nature of the hospital, and the demands of the medical staff upon the laboratory.

2) Basic laboratory services, necessary for routine examinations as defined in subsection (b) ~~of this Section~~, are provided in the hospital.

b) Clinical Laboratory Examinations. Provisions shall be made to carry out basic clinical laboratory examinations including chemistry, microbiology, hematology, serology, and clinical microscopy in such depth as required by the medical staff.

1) Other laboratory examinations may be provided under arrangements by the hospital with another laboratory which is certified under CLIA regulations~~88~~.

2) In the case of work performed by an outside laboratory, the original report

from this laboratory shall be contained in the medical record as specified in subsection (f) ~~of this Section~~.

c) Availability of Facilities and Services

- 1) Facilities and services shall be available at all times. Adequate provision shall be made for assuring the availability of emergency laboratory services, either in the hospital or under arrangements with a laboratory which meets the requirements of subsection (b) ~~of this Section~~.
- 2) Such services shall be available 24 hours a day, 7 days a week, including holidays. Coverage of the service is permissible by having arrangements with personnel for "on call duty."
- 3) Where services are provided by an outside laboratory, the conditions, procedures, and availability of examinations performed are to be in writing and available in the hospital.

d) Required Examinations. The laboratory examinations required on all admissions shall be determined by the medical staff as provided in Section 250.240(c).

e) Laboratory Report.

Signed or otherwise authenticated reports shall be filed with the patient's medical record and duplicate copies are maintained in the laboratory.

- 1) The laboratory director shall be responsible for the laboratory reports.
- 2) There shall be a policy for assuring that all tests and procedures are ordered by a member of the medical staff or by others in accordance with approved policies. (See Section 250.330)

f) Pathologist Services. Services of a pathologist shall be provided as indicated by the needs of the hospital.

- 1) Services are to be under the supervision of a pathologist certified by the American Board of Pathology or who possesses training and experience acceptable to the Department and equivalent to such certification, and licensed to practice medicine in all its branches in Illinois, on a full-time, regular part-time or regular consultative basis. If the latter pertains, the hospital shall provide for, at a minimum, semimonthly consultative visits by a pathologist.
- 2) The pathologist shall participate in staff, departmental and

clinicopathologic conferences.

- g) Tissue Examination. All tissues removed at operation are to be submitted for examination. The extent of examination is determined by the pathologist.
- 1) All tissues removed from patients at surgery shall be macroscopically, and if necessary, microscopically examined by the pathologist, with the exception of the following tissues and materials, which do not need to be examined by a pathologist:
 - A) Foreskin, fingernails, toenails, and teeth that are removed during surgery;
 - B) Bone, cartilage, normal skin and scar tissue that are coincidentally removed during the course of cosmetic or corrective surgery;
 - C) Cataract lenses that are removed during the course of eye surgery; ~~and~~
 - D) Foreign substances (e.g., wood, glass, pieces of metal including previously inserted surgical hardware) that are removed during surgery; ~~and~~ and.
 - E) Placenta and placental tissue, unless requested by the delivering physician or practitioner.
 - 2) The pathologist is responsible for verifying the receipt of tissues for examinations.
 - 3) A list of tissues which routinely require microscopic examination shall be developed in writing by the pathologist with the approval of the medical staff.
 - 4) A tissue file shall be maintained and include, as a minimum, reports, slides and cross-index.
 - 5) In the absence of a pathologist, there shall be an established plan for sending to a pathologist outside the hospital all tissues requiring examination. The pathologist may refer tissues to another pathologist for consultation when he deems necessary.
- h) Reports of Tissue Examination. Signed reports of tissue examinations are to be filed with the patient's medical record and duplicate copies are to be maintained.

- 1) All reports of macro and microscopic examinations performed shall be signed by the pathologist.
- 2) Provisions are to be made for the prompt filing of examination results in the patient's medical record and notification of the physician requesting the examination.
- 3) Duplicate copies of the examination reports are to be maintained in a manner which permits ready identification and accessibility.

(Source: Amended at 47 Ill. Reg. _____, effective _____)

SUBPART J: SURGICAL AND RECOVERY ROOM SERVICES

Section 250.1270 Surgical Patients

- a) Patients undergoing major surgical procedures shall be observed both pre-operatively and post-operatively by a competent nurse specifically assigned to the duty. Such observations shall be documented in the patient's record.
- b) The chart of the patient shall accompany him to the operating suite, to the recovery area and be returned with the patient to the patient care unit.
- c) All tissue/specimens removed at surgery, except those exempted by Section 250.510(g)(1), shall be placed in a container properly labeled and submitted for pathological examination.
- d) An operative report describing techniques and findings shall be written or dictated immediately following surgery and signed by the surgeon.
- e) All infections of clean surgical cases shall be recorded and reported to administration and to the Infection Control Committee. The Infection Control Committee shall determine a procedure for the surveillance of such cases.

(Source: Amended at 47 Ill. Reg. _____, effective _____)

SUBPART L: RECORDS AND REPORTS

Section 250.1520 Reports

- a) Each hospital shall submit reports containing such pertinent data as may reasonably be required by the Department.

- b) In the reporting of communicable disease cases, the hospital shall comply with the Control of Communicable Diseases Code.
- c) See Sections 250.1830 and 250.1840 regarding reports pertaining to mothers and infants, and regarding children to be discharged to a person other than a natural parent.
- d) See Section 250.1830 regarding birth, stillbirth and death reports.
- e) The death of a pregnant woman or the death of a woman within one year following the termination of a pregnancy shall be reported to the Department as required by the Department's rules titled Maternal Death Review and in Section 250.1830(i)(2). This is required regardless of the type of hospital or the reason for the patient's admission.
- f) Any incident or occurrence in a hospital that could be considered a catastrophe or creates a potential immediate jeopardy or dangerous threat that requires the transfer of patients to other parts of the facility or other facilities, including but not limited to fire, flood, or power failure, shall be reported to the Department within 24 hours after the occurrence. Reports shall be made to the Department via email at: DPH.HospitalReports@illinois.gov.
- g) Reporting Opioid Overdoses
- 1) *As used in this Section, the following definitions apply:*

"Overdose" – has the same meaning as provided in Section 414 of the Illinois Controlled Substances Act.

"Health care professional" – a physician licensed to practice medicine in all its branches, a physician assistant, or an advanced practice registered nurse licensed in Illinois.
 - 2) *When treatment is provided in a hospital's emergency department, a health care professional who treats a drug overdose, hospital administrator, or the designee of either shall report the case to the Department of Public Health within 48 hours after providing treatment for the drug overdose or at such time the drug overdose is confirmed.*
 - 3) The hospital shall report to the Department the following information electronically or on forms provided by the Department:

- 1672 A) *Whether an opioid antagonist was administered* and, if yes, the
 1673 name of the antagonist;
 1674
 1675 B) *The cause of the overdose*, including, but not limited to, whether
 1676 the overdose was caused by an opioid or heroin; *and*
 1677
 1678 C) *The demographic information of the person treated.* The
 1679 demographic information shall include, but is not limited to, the
 1680 patient's:
 1681
 1682 i) Age;
 1683
 1684 ii) Sex;
 1685
 1686 iii) Federal Information Process Standards county code;
 1687
 1688 iv) Zip code;
 1689
 1690 v) Race, using the Centers for Disease Control and Prevention
 1691 (CDC) race category; and
 1692
 1693 vi) Ethnicity, using the CDC ethnicity group.
 1694
 1695 4) *The person completing the form shall not disclose the name, address, or*
 1696 *any other personal information of the individual experiencing the*
 1697 *overdose.*
 1698
 1699 5) *The identity of the person and hospital reporting under this subsection (g)*
 1700 *shall not be disclosed to the subject of the report. For the purposes of this*
 1701 *subsection (g), the health care professional, hospital administrator, or*
 1702 *designee making the report, and his or her employer, shall not be held*
 1703 *criminally, civilly, or professionally liable for reporting under this*
 1704 *subsection (g)(5), except for willful or wanton misconduct. (Section 6.14g*
 1705 *of the Act)*
 1706
 1707 h) Each hospital shall notify the Department within 24 hours after receiving a notice
 1708 of impending strike of staff providing direct care. The hospital shall submit a
 1709 strike contingency plan to the Department no later than three calendar days prior
 1710 to the impending strike.
 1711
 1712 i) Hospitals without a licensed pediatric unit that provide limited inpatient or
 1713 observation services to pediatric patients (neonate (less than 28 days of age) to 14
 1714 years old ~~and younger~~) shall report the following information to the Department

quarterly, on a form to be provided by the Department:

- 1) The number of pediatric patients admitted or under observation;
- 2) The number of pediatric mortalities;
- 3) The number of pediatric patients admitted and ultimately transferred; and
- 4) A breakdown of those pediatric patients that were transferred via the emergency department, post-procedure, or from an in-patient or observation status setting.

j) Consulting hospitals shall report the following information to the Department quarterly:

- 1) The number of pediatric consultations provided; and
- 2) The costs incurred for providing the pediatric consultations.

(Source: Amended at 47 Ill. Reg. _____, effective _____)